Instructions for Completing the

Application for Hoosier Healthwise For Children and Pregnant Women

Hoosier Healthwise (HHW) is the State of Indiana's health care program for children, pregnant women, and families with low income. Based on family income, children up to age 19, pregnant women, and parents or guardians of children under the age of 18 may be eligible for coverage.

COMMON TERMS DEFINED

***Applicant*:** Includes anyone listed as living in your household who is applying for health coverage (Question 1, last column).

***Household*:** Persons living in the same home, including adults who are not related.

You* or *Yours: The person completing the HHW application.

INSTRUCTIONS

Question 1: *Tell us about the members of your family living in your household.*

Provide the name and other basic information about the people who live in your household. Make sure to put a checkmark in the last column to show who in the household is applying for health coverage.

In column eight of this section, you are asked if individuals listed on the application are citizens of the U.S.

- If the answer is 'No,' then some type of proof of immigration status is needed. *For example, an immigration document or document number like an alien registration number.*
- If the answer is 'Yes,' proof of citizenship is needed. For example, a birth certificate or passport.

It does not matter whether the person filling out the application or either of the child's parents are a U.S. citizen. The application refers only to the children and pregnant women who need health care. The HHW program does not report undocumented immigrants to the U.S. Citizen and Immigration Services (USCIS, formerly known as INS).

Question 2: *Tell us your address and telephone number.*

As the person completing the application on behalf of the children and/or pregnant woman, write your home and/or mailing address, including the county where you live, and your phone number and email address.

The last part of this question asks if you would like to receive automated calls from our agency. If you check 'Yes,' you will only be called about your application or case. Examples of calls you may receive are appointment reminders or due dates for requested documents.

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Question 3: Health Plan Selection

If your application is approved, you will need to enroll in one of the HHW health plans. A *health plan* is a group of health care providers (doctors, specialists, home health care providers, pharmacies, therapists etc.) If you are approved for HHW, you will need to enroll in one of the HHW health plans:

- Anthem, http://anthem.com/inmedicaid/
- Managed Health Services (MHS), http://www.mhsindiana.com/
- MDwise, http://www.mdwise.org/hoosierhealthwise/

You must use health care providers who are in your health plan for most services. It is important for you to know which plan the doctor of your choice is in when you choose your health plan.

If you gave your email address in Question 2, you will receive an email with a provider directory. Check 'Yes' if you wish to receive a paper copy in the mail.

If you do not select a health plan when you submit your application, or if you need to pick a doctor that works with your plan, call the HHW Helpline at **1-800-889-9949**. You can also learn more about picking a health plan by reading *How to Select a Health Plan* on the IndianaMedicaid.com website.

Question 4: *Do the applicants live in Indiana*?

Applicant refers to the persons applying for health care. Check 'No' if any applicant listed does not live in Indiana.

Question 5: *Does any applicant have a court-appointed legal guardian*?

Applicant refers to the persons applying for health care. Check 'Yes' if any applicant listed has a court-appointed legal guardian.

Question 6: *Are any of the applicants pregnant*?

Applicant refers to the persons applying for health care. Check 'Yes' if any applicant listed is pregnant. If you check 'Yes,' you will be required to provide a signed statement from a licensed health professional confirming the pregnancy and expected date of delivery.

Question 7: *Are any of the applicants blind or disabled*?

Applicant refers to the persons applying for health care. Check 'Yes' if any applicant listed in Question #1 is blind or has a disability.

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Questions 8 – *Do you pay for child care*? *Do you pay for an incapacitated adult*?

Check 'Yes' if you spend money for things like child care or adult daycare out of your income. *Incapacitated* refers to a person in the care of a parent or guardian because they are unable to provide reasonable self-care due to illness or a physical or mental disability.

If you pay for child care or care for an incapacitated adult out of your income, HHW may be able to subtract some of these expenses from what is used for your income total. For example:

- Up to $200 per month per child may be subtracted for child care expenses for children under two years old.
- Up to $175 per month per child may be subtracted for children two years and older.

The total income , after subtractions, is used to see if the child or incapacitated adult is eligible for HHW.

Questions 9: *Does anyone living in the household pay support payments*?

Check 'Yes' if anyone living in the home pays support payments. Support payments may be used to see if an applicant is eligible for HHW.

Questions 10: *Are any of the applicants covered by health insurance now*?

An applicant who is covered by private health care insurance may still be eligible for HHW. If you check 'Yes,' you must provide proof of health insurance coverage. Please provide the following information on a separate sheet of paper:

- Name, address, and phone number of the insurance company
- Name of the individual who has the policy and the policy number
- Names of the individuals covered under the policy
- Type of coverage *(such as hospitalization)*

Question 11: *Did any applicants who do not have health insurance lose coverage in the past 3 months?*

If you check 'Yes,' list each applicant's name, when coverage ended, and the reason why coverage was lost. If health insurance was dropped voluntarily, the children are not eligible for the Children's Health Insurance Program (CHIP)-Package C for three months following the cancellation.

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Question 12: ***Tell us how much work income you and other members of your family make*****.**

Please list **each** person living in the home who is employed. If you need more space, attach an extra sheet of paper.

If possible, provide this information when you submit your application. The sooner you provide proof of all income earned last month, the faster we will be able to tell you if applicants are eligible for HHW. Proof must be a document from the company, person, or organization paying the income, such as:

- Pay stubs or a signed statement from your employer
- Last year's income tax return (if someone in the home is self-employed)

When all income for the household is added together, we look at the gross amount and subtract $90. *Gross income* is the amount earned before taxes and other deductions are subtracted.

If money is spent on care for a child or care for an incapacitated adult living in the home, more money is subtracted from your income total (see question 8).

Question 13: ***Tell us if you or any family members receive other income from the types listed here***.

For each person living in the home, list income from all sources other than work. If no one in the home gets non-work income, you must initial in the space provided.

Use the boxes just below the list to provide your response. On each line, separately write in the type of income received by each person in the home. If you need more space, attach an extra sheet of paper.

For each line, include the following:

- Column 1, write the name of the individual who earns the income
- Column 2, write the number for the type of income from the choices listed. If the answer is 'Other,' explain and attach documentation or proof of income.
- Column 3, list how often the individual gets paid. For example, weekly, monthly, yearly.
- Column 4, list the date the individual first began to get this income.
- Column 5, list the amount received with each payment. Do not list an annual amount if the applicant is paid more often. For example, if you list 'monthly' in the 3rd column, write the amount received each month.

It is helpful if you attach documentation for each type of income with this application. For example, an award letter showing the current amount of pension or benefit, or a statement of child support from a non-custodial parent. *Remember, if you can't get proof of income right away or if you are not sure about what to send, it's fine to submit the application without them.*

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Question 14: ***Was the household income in the prior 3 months the same as it is now*****?**

If you check 'Yes' that your family's household income for this month is the same as in the last three months, then proof of income received this month is all you need to provide. However, if you check 'No' that your family's income this month is different from the last three months, then proof of income for each of the last three months may be needed to be considered for retroactive coverage.

Question 15: ***Signature***

By signing the application, you are agreeing that the information you provided on the application is correct to the best of your knowledge. Any individual who receives HHW benefits by giving false information on purpose or by failing to report information may be criminally prosecuted under State and Federal law. The value of benefits received by an individual who was not entitled to receive them must be repaid to the Hoosier Healthwise program.

Your signature also means that you agree to pay the premiums and co-payments if your children are found eligible for Package C - Children's Health Plan. Agreeing to pay the premiums and co-payments is a requirement of being eligible for Package C.

Question 16: ***Do you want to register to vote*****?**

Your answer will have no impact on your (or any family member's) eligibility for HHW benefits. If you answer 'Yes,' a voter registration application will be mailed to you.

You may also register to vote at any FSSA Division of Family Resources office or online at http://www.in.gov/fssa/dfr/4248.htm.